Authorization to Disclose Protected Health Information

Regional Medical Center / Regional Family Health
Health Information Services, Release of Information
PO Box 359 Manchester, IA 52057 Phone: (563) 927-7433

Please use black ink, neatly PRINT (except signature) and provide complete information in each section

Patient Name: _____ **Date of Birth:** _____
Last First MI

Patient Address: _____ **Phone:** _____

Information From: (Provide name and address of person/institution)	**Information To:** (Provide name and address of person/institution)

Please check the reason for release of protected health information:

❑ Transferring Medical Care ❑ Moving Out of Area ❑ Legal Use ❑ Insurance Coverage ❑ Two-way Communication
❑ Personal File (payment may be required) ❑ Lay Caregiver
❑ Other (specify) _____

Please check the information to be disclosed via paper, verbal or electronic exchange. Include dates where indicated:

❑ Immunization Record _____
❑ History & Physical (date) _____
❑ Discharge Summary (date) _____
❑ Emergency Department Note (date) _____
❑ Laboratory Results (specify type or date) _____
❑ Test Results (i.e. EKG, PFT, etc) (specify type or date) _____
❑ Consultation Report(s) (specify type or date) _____
❑ Radiology & Imaging Reports (specify type or date) _____
❑ Radiology Images on CD (specify type or date) _____
❑ Clinic Records (date) _____
❑ Behavioral Services Records (date) _____
❑ Billing Information (specify type or date) _____
❑ Discharge Instructions / Aftercare Assistance Instructions (date) _____
❑ Other (specify) _____

Preferred method of delivery:

❑ In Person ❑ Mail ❑ CD ❑ Fax
❑ Encrypted Email ❑ Un-encrypted email; I understand & accept the risks Email address: _____

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance use, mental health, AIDS-related information, and/or genetic-related information. I authorize the release of confidential information relating to the following categories, unless I specifically deny the release.

Initial any category NOT to be released.

_____ HIV or AIDS Related Information
_____ Mental Health (except not psychotherapy notes)
_____ Substance Use or Abuse (includes drugs or alcohol)
_____ Genetic testing/information (Refers to genetic testing to screen for a possible future health issue)

Regional Medical Center MANCHESTER, IOWA (563) 927-3232 Regional Family Health 563 927-7777 A service of Regional Medical Center www.regmedctr.org

Authorization to Disclose Protected Health Information

Please read the following statements carefully: This authorization is voluntary. I may refuse to sign this authorization or revoke this authorization at any time. I understand that this authorization is valid up to one year from the date signed. I understand that my revocation or refusal to sign this authorization will not affect treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable). I understand that if I revoke this authorization, revocation will take effect on the day it is received in the Health Information Services Department and upon receipt of written revocation, the entity will stop using or disclosing information except to the extent it already took action in reliance on the authorization. I understand that I may inspect or copy the health information disclosed at any time. I understand there may be a reasonable charge to obtain a copy of these records. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulation or a business associate with these entities, the information described above may be re-disclosed and no longer protected by the federal privacy regulations.

Signature of Patient or Legal Representative

Date Signed

If signed by Legal Representative, Relationship to Patient

Notice to Receiving Person/Agency/Entity: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

Internal Use Only. **Employees check the boxes below:**

❑ Identification Verified ❑ Copy of signed authorization given to patient

❑ Obtained HCPOA or Court Document, if necessary, & attach OR ❑ HCPOA or Court Document on file in EHR

❑ Copy of signed authorization given to receiving person / agency / entity